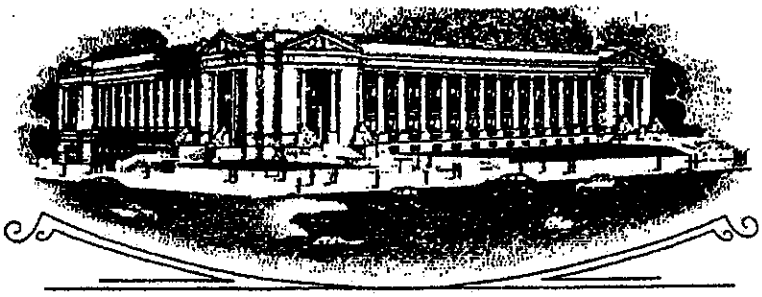


SHELBY COUNTY COURTHOUSE
JIMMY MOORE
CLERK OF THE CIRCUIT COURT
SHELBY COUNTY

MEMPHIS, TN 38103-2099

This is to certify that these Sixty-One pages are a true and complete copy of:

Whole Entire File

Anthony Snow, individually and as next kin of
Jessie M Snow, Deceased,

VS *CT-002067-10*

Timothy L. Kemp, M.D., THMS West TN MC, LLC,
And Baptist Memorial Hospital- Collierville

Witness my hand and seal of Court on this 14th Day of May, 2010

S/Jimmy Moore
CIRCUIT COURT CLERK

DEPUTY COURT CLERK

Blumberg No. 5116 EXHIBIT A

IN THE CIRCUIT COURT OF TENNESSEE FOR THE THIRTIETH JUDICIAL DISTRICT AT MEMPHIS, SHELBY COUNTY

FILED
APR 22 2010
CIRCUIT COURT CLERK
BY D.C.

ANTHONY SNOW, Individually and as Next of Kin of JESSIE M. SNOW, Deceased,

Plaintiff,

v.

TIMOTHY L. KEMP, M.D., THMS WEST TENNESSEE MC, LLC, and BAPTIST MEMORIAL HOSPITAL – COLLIERVILLE,

Defendants.

Div. VII

Docket No. CT-002067-10

Jury Demanded

COMPLAINT FOR DAMAGES

The Plaintiff, Anthony Snow, Individually and As Next of Kin of Jessie M. Snow, Deceased ("Patient"), files this Complaint for Damages against the Defendants, Timothy L. Kemp, M.D., THMS West Tennessee MC, LLC, and Baptist Memorial Hospital – Collierville ("Defendants"):

PARTIES AND JURISDICTION

1. The Plaintiff, Anthony Snow, is a resident and citizen of Holly Springs, Marshall County, Mississippi, and has been such at all times pertinent to this Complaint and brings this action as husband and next-of-kin for Jessie M. Snow, Deceased, pursuant to Tenn. Code Ann. §§ 20-5-101 *et seq*.

2. The Defendant, Timothy L. Kemp, M.D. ("Dr. Kemp"), is an adult resident of Shelby County, Tennessee, and has been such at all times pertinent to this Complaint.

3. Defendant, Dr. Kemp, provided medical services to the Patient on or about January 2, 2009, at Baptist Memorial Hospital-Collierville.

4. Defendant, Dr. Kemp, was acting as the employee, servant and/or agent, ostensible, apparent or otherwise, of THMS West Tennessee MC, LLC, at all times relevant hereto.

5. Defendant, Dr. Kemp, was also acting as the apparent agent of Baptist Memorial Hospital – Collierville at all times relevant hereto.

6. Defendant, Dr. Kemp, can be served at his regular place of business, 1500 West Poplar, Collierville, Tennessee 38017.

7. Upon information and belief, THMS West Tennessee MC, LLC, was a professional corporation doing business in Collierville, Shelby County, Tennessee at all times pertinent to this action.

8. THMS West Tennessee MC, LLC, can be served through its agent for service of process, Corporation Service Company, 2908 Poston Avenue, Nashville, Tennessee 37203.

9. Upon information and belief, Defendant, Baptist Memorial Hospital – Collierville ("Baptist - Collierville") is and was at all times relevant hereto a hospital facility licensed in and by the state of Tennessee.

10. The Defendant, Baptist-Collierville, can be served through its agent for service of process, Mr. Greg Duckett, 350 North Humphreys Boulevard, Memphis, Tennessee 38120.

11. Defendant, Baptist – Collierville, offered general medical and surgical services and was required by statute to provide a hospital emergency service in accordance with rules and regulations enacted by the Tennessee Department of Health. TENN. CODE ANN. § 68-140-301.

12. Defendant, Baptist – Collierville, provided medical services to Patient within the Collierville, Shelby County, Tennessee area on or about January 2, 2009.

13. Defendant, Baptist – Collierville, is vicariously or otherwise liable for the acts and/or omissions of its employees, agents and/or servants, ostensible or otherwise, who provided care and/or treatment to Patient including, but not limited to, Defendant, Dr. Kemp.

14. All of the events which form the basis of this Complaint occurred in Collierville, Shelby County, Tennessee.

15. Venue is properly situated in Memphis, Shelby County, Tennessee.

16. This Court has jurisdiction over the subject matter of this litigation.

17. This Court has jurisdiction over the parties to this litigation.

18. The Plaintiff fully complied with the provisions of *Tenn. Code Ann* § 29-26-122 (a) by properly serving the Defendants with written notice of this claim at least sixty (60) days before filing this Complaint.

19. Copies of the affidavits of service and written notice served on the Defendants are attached hereto as **Exhibit A**.

20. The Plaintiff fully complied with the provisions of Tenn. Code Ann. § 29-26-122 by properly filing a Certificate of Good Faith ("Certificate") simultaneously with this Complaint.

21. A copy of the Plaintiff's Certificate referenced above is attached hereto as **Exhibit B**.

FACTUAL BACKGROUND

22. On or about January 2, 2009, Patient arrived at Baptist – Collierville at approximately 10:24 a.m., limping and complained of pain and swelling in her left calf (9 out of 10 point scale) accompanied by shortness of breath.

23. Defendant, Timothy L. Kemp, M.D. ("Dr. Kemp"), was the Emergency Department physician that assumed the responsibility for the Patient's care.

24. Dr. Kemp was advised of Patient's presenting complaints.

25. At approximately 10:45 a.m., Dr. Kemp took a history of the Patient which revealed the onset date of her left calf pain as December 22, 2008, a patient-reported history of deep venous thrombosis, a recent emergency room visit complaining of left calf pain and recent episodes of palpitations and shortness of breath.

26. Dr. Kemp conducted a physical examination of the Patient in which he noted swelling and pitting of the left calf and foot.

27. Dr. Kemp ordered a comprehensive metabolic panel, complete blood count and a D-dimer test (which is used to help diagnose thrombosis).

28. At or about 11:28 a.m., the D-dimer test resulted in an abnormally high measurement of 4.0 ug/ml on a reference range of less than 0.50 ug/ml being normal.

29. Dr. Kemp then ordered a Venous Doppler Ultrasound of the left calf and the results were interpreted at 12:25 p.m. as negative for deep venous thrombosis.

30. The Patient was discharged home by Dr. Kemp at 1:10 p.m., who noted her condition as "unchanged."

31. Despite the Patient presenting with a self-reported history of deep venous thrombosis, swelling, pain and pitting in her lower left extremity, recent episodes of palpitations and shortness of breath, a recent emergency room visit for left calf pain, current complaints of shortness of breath and a highly elevated D-dimer result, Defendant, Dr. Kemp, chose not to begin anticoagulation therapy.

32. Despite the Patient presenting with a self-reported history of deep venous thrombosis, swelling, pain and pitting in her lower left extremity, recent episodes of palpitations and shortness of breath, a recent emergency room visit for left calf pain, current complaints of shortness of breath and a highly elevated D-dimer result, Defendant, Dr. Kemp, chose not to order a chest CT.

33. Despite the Patient presenting with a self-reported history of deep venous thrombosis, swelling, pain and pitting in her lower left extremity, recent episodes of palpitations and shortness of breath, a recent emergency room visit for left calf pain, current complaints of shortness of breath and a highly elevated D-dimer result, Defendant, Dr. Kemp, chose not to conduct an appropriate study to rule out pulmonary embolus/emboli.

34. Despite continued reports of pain in her left calf, the Patient was discharged home at 1:20 p.m. (3 hours after her arrival) and was given prescriptions for Lortab and Ibuprofen for pain and given follow-up instructions to see a doctor in two to three days unless better.

35. The day after her discharge, the Patient died at home on January 3, 2009, at approximately 5:45 p.m.

36. According to the Mississippi State Department of Health Certificate of Death, signed by James L. Anderson, MEI, the cause of death was saddle pulmonary thromboembolus, deep venous thrombosis (left lower extremity) and right ventricular dilatation of heart. A copy of same is attached hereto as **Exhibit C**.

CAUSE OF ACTION FOR NEGLIGENCE

37. Defendants, Timothy L. Kemp, M.D., THMS West Tennessee MC, LLC, and Baptist Memorial Hospital – Collierville, individually and/or vicariously, by or through their agents, servants and employees, are guilty of one (1) or more of the following acts of negligence, each and every such act being a direct and proximate cause of Plaintiff's damages and injuries:

(a) Negligently and carelessly failing to order an appropriate work up to rule out the diagnosis of pulmonary embolism;

(b) Negligently and carelessly failing to order appropriate anticoagulation therapy in a timely manner;

(c) Negligently and carelessly failing to otherwise properly evaluate, diagnose and/or treat Patient's medical condition in a timely manner;

(d) Negligently and carelessly failing to exercise that degree of care and skill required of a reasonable and prudent physician under the same or similar circumstances in cities such as Collierville, Shelby County, Tennessee in 2008; and

(e) Negligently and carelessly deviating from the recognized standard of acceptable professional practice required and expected of these Defendants under the circumstances that existed at all times relevant hereto.

38. Defendant, Baptist - Collierville, owed Patient a non-delegable duty to provide medical care and treatment in the Emergency Department and hospital floor that complied with the recognized standard of acceptable professional practice.

39. Defendant, Baptist – Collierville, breached that non-delegable duty (as noted above) and is thus liable to Patient for the acts and/or omissions that occurred in the Emergency Department and hospital floor on or about January 2, 2009.

INJURIES AND DAMAGES

40. The Patient was survived by her husband, Anthony Snow.

41. The Plaintiff and Patient suffered harms and losses as the sole, direct and proximate cause of the professional negligence, and deviation from the recognized standard of acceptable professional practice on the part of the Defendants.

42. As the direct result of the Defendants' negligence as herein alleged, Anthony Snow, as the deceased Patient's next-of-kin, is entitled to recover damages, including but not limited to, the following specific items of damage:

a. The mental and physical suffering actually endured by the Patient;

b. Medical expenses necessitated by the Defendants' negligence, including expenditures for doctors, nurses, hospital care, medicine and drugs;

c. Reasonable funeral expenses;

d. Loss of earning capacity before the Patient's death and future;

e. Damages pursuant to the wrongful death of Plaintiff's wife, Jessie M. Snow, including the loss of love, affection, companionship, care, and attention;

f. Damages related to great mental anguish and suffering as a result of the death of Plaintiff's wife on or about January 3, 2009;

g. Loss of the pecuniary value of the deceased Patient's life; and

h. Other damages allowed by law.

VICARIOUS LIABILITY

43. Defendant, THMS West Tennessee MC, LLC, is vicariously liable for the acts and omissions of all its employees, servants and agents including, but not limited to, Dr. Kemp and every other member of its staff who provided care and treatment to the Patient on or about January 2, 2009.

44. Defendant, Baptist – Collierville, is vicariously liable for the acts and omissions of all its employees, servants and agents including, but not limited to, Dr. Kemp and every other member of its staff who provided care and treatment to the Patient on or about January 2, 2009.

WHEREFORE, the Plaintiff sues the Defendants herein for compensatory damages in an amount to be determined by the jury, for costs herein, and for all such other and further relief, both general and specific, legal and equitable, to which the Patient and Plaintiff are entitled by law.

Respectfully submitted,

THE COCHRAN FIRM – MEMPHIS

One Commerce Square, Suite 2600
Memphis, Tennessee 38103
(901) 217-7000 [Telephone]
(901) 333-1897 [Facsimile]

By: _____
Bobby F. Martin, Jr. (TNBPR No. 19488)

STATE OF TENNESSEE)
)
COUNTY OF SHELBY)

Comes now the Affiant, Wendy Sorrels, who, having first been duly sworn, makes oath that the following statements are true:

1. My name is Wendy Sorrels. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.

2. On December 17, 2009, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of December 17, 2009, the below notices and all enclosures to Baptist Memorial Hospital – Collierville, Mr. Glenn F. Baker, Administrator and Chief Executive Officer at the address of 1500 West Poplar, Collierville, Tennessee 38017, Mr. Greg Duckett, Registered Agent for Baptist Memorial Hospital - Collierville, at the address of 350 North Humphreys Boulevard, Memphis, Tennessee 38120, Timothy L. Kemp, M.D. at the address of South Emergency Associates/Baptist Collierville Hospital, 1500 West Poplar, Collierville, Tennessee 38017, South Emergency Associates, P.C. at the address of 8596 Rockcreek Parkway, Cordova, Tennessee 38016, and Fred J. Adcock, III, M.D., Registered Agent for South Emergency Associates, P.C., at the address of 8596 Rockcreek Parkway, Cordova, Tennessee 38016 as required by T.C.A. § 29-26-121(a):

   Exhibit 1, which is the notice letters.

   Exhibit 2, which is the list of the names and addresses of all providers who were being sent a notice pursuant to T.C.A. § 29-26-121 (a).

   Exhibit 3, which is HIPAA compliant medical authorizations permitting Baptist Memorial Hospital – Collierville to obtain complete medical records from providers Timothy L. Kemp, M.D. and South Emergency Associates, P.C. who were sent a notice.

   Exhibit 4, which is HIPAA compliant medical authorizations permitting Timothy L. Kemp, M.D. to obtain complete medical records from providers Baptist Memorial Hospital – Collierville and South Emergency Associates, P.C. who were sent a notice.

   Exhibit 5, which is HIPAA compliant medical authorizations permitting South Emergency Associates, P.C. to obtain complete medical records from providers Baptist Memorial Hospital – Collierville and Timothy L. Kemp, M.D. who were sent a notice.

Exhibit 6, which is copies of the Certificate of Mailings from the U.S. Postal Service, stamped with the date of mailing.

Exhibit 7, which is copies of the return receipt cards that accompanied the notice letters sent by certified mail.

Wendy Sonels
SIGNATURE

Date: 12/17/09

Subscribed and sworn to before me this 17th day of December, 2009.

Sheila E. Boyer
NOTARY PUBLIC

SHEILA E. BOYER STATE OF TENNESSEE NOTARY PUBLIC COUNTY OF SHELBY

My commission expires: MY COMMISSION EXPIRES OCTOBER 26, 2011

THE COCHRAN FIRM
MEMPHIS

ONE COMMERCE SQUARE • 26TH FLOOR • MEMPHIS, TENNESSEE 38103
(901) 523-1222 • FAX: (901) 523-1999
WWW.COCHRANFIRM.COM

December 17, 2009

TN19156

Baptist Memorial Hospital - Collierville
Mr. Glenn F. Baker, Administrator and
Chief Executive Officer
1500 West Poplar
Collierville, Tennessee 38017

VIA CERTIFIED MAIL

RE: Jessie Mae Snow, Deceased
Notice Required by T.C.A. § 29-26-121 (a)

Dear Mr. Baker:

I am the attorney representing Jessie Mae Snow, Deceased and Anthony Snow, Jr., Husband. Through me and my firm, Anthony Snow, Jr. is asserting a potential claim for medical malpractice against your hospital. This claim arises out of care provided by employees and/or agents of your hospital, to, and/or on behalf of, the hospital's patient, Jessie Mae Snow, Deceased, while Jessie Mae Snow, Deceased was at your hospital at 1500 West Poplar, Collierville, Tennessee 38017 during her admission beginning on/about January 2, 2009.

The full name and date of birth of the patient whose treatment is at issue are:

Jessie Mae Snow, Deceased
Date of Birth: November 13, 1974

The name and address of the claimant authorizing this notice and relationship to the patient are:

Anthony Snow, Jr., Husband
140 Jordon Road
Holly Springs, Mississippi 38635

EXHIBIT
tabbies
1

TENNESSEE LICENSED ATTORNEYS
JOHNNIE L. COCHRAN, JR. (1937-2005)
SAMUEL A. CHERRY, JR. [1,3]
JOCK M. SMITH [1,3,6]
DONALD W. BUCKLER [4]
H. SCOTT BATES [4]
KEITH R. MITNIK [4]
ALEXANDER M. CLEM [4]
DAVID A. MCLAUGHLIN [2]
DANESE K. BANKS
W. BRYAN SMITH
GARRY J. RHODEN [4,5,7]
BOBBY F. MARTIN, JR. [2,5]
BILL M. WADE [2]
PETER B. GEE, JR. [2,5]
MARK A. LAMBERT [5]

ALSO ADMITTED IN:
[1] ALABAMA
[2] ARKANSAS
[3] DISTRICT OF COLUMBIA
[4] FLORIDA
[5] MISSISSIPPI
[6] NEW YORK
[7] KENTUCKY

The name and address of the attorney sending this notice are:

Bobby F. Martin, Jr., Esq.
The Cochran Firm - Memphis
One Commerce Square, 26th Floor
Memphis, Tennessee 38103

Enclosed herein is a list of the names and addresses of all providers being sent a notice.

Enclosed are HIPAA compliant medical authorizations permitting your hospital to obtain complete medical records from each other provider being sent a notice.

I know that you will send a copy of this correspondence and all enclosures to your professional liability insurance carrier and/or your risk manager and/or your legal counsel. You are welcome to contact me, or your representative is welcome to contact me. I would appreciate hearing from someone about this matter as soon as possible.

Thank you very much.

Sincerely,

THE COCHRAN FIRM - MEMPHIS

Bobby F. Martin, Jr., Esq.
Email: bmartin@cochranfirm.com

BFM/ws

Enclosures

THE COCHRAN FIRM
MEMPHIS

ONE COMMERCE SQUARE • 26TH FLOOR • MEMPHIS, TENNESSEE 38103
(901) 523-1222 • FAX: (901) 523-1999
WWW.COCHRANFIRM.COM

December 17, 2009

TN19156

Mr. Greg Duckett
Registered Agent for Baptist Memorial
Hospital - Collierville
350 North Humphreys Boulevard
Memphis, Tennessee 38120

VIA CERTIFIED MAIL

RE: Jessie Mae Snow, Deceased
Notice Required by T.C.A. § 29-26-121 (a)
Baptist Memorial Hospital - Collierville

Dear Mr. Duckett:

You are listed with the State of Tennessee as the agent for service of process for Baptist Memorial Hospital - Collierville.

I am the attorney representing Jessie Mae Snow, Deceased and Anthony Snow, Jr., Husband. Through me and my firm, Anthony Snow, Jr. is asserting a potential claim for medical malpractice against Baptist Memorial Hospital - Collierville. This claim arises out of care provided by Baptist Memorial Hospital – Collierville to the patient, Jessie Mae Snow, Deceased, at Baptist Memorial Hospital - Collierville, 1500 West Poplar, Collierville, Tennessee 38017 during her admission beginning on/about January 2, 2009.

The full name and date of birth of the patient whose treatment is at issue are:

Jessie Mae Snow, Deceased
Date of Birth: November 13, 1974

The name and address of the claimant authorizing this notice and relationship to the patient are:

Anthony Snow, Jr., Husband
140 Jordon Road
Holly Springs, Mississippi 38635

The name and address of the attorney sending this notice are:

Bobby F. Martin, Jr., Esq.
The Cochran Firm - Memphis
One Commerce Square, 26th Floor
Memphis, Tennessee 38103

Enclosed herein is a list of the names and addresses of all providers being sent a notice.

Enclosed are HIPAA compliant medical authorizations permitting Baptist Memorial Hospital – Collierville to obtain complete medical records from each other provider being sent a notice.

Please forward this correspondence to the appropriate individuals at Baptist Memorial Hospital – Collierville to the professional liability insurance carrier and/or legal counsel of Baptist Memorial Hospital - Collierville. Please ask a representative of the professional liability insurance carrier insuring Baptist Memorial Hospital – Collierville for this claim, and/or legal counsel, to contact me.

Thank you.

Sincerely,

THE COCHRAN FIRM – MEMPHIS

Bobby F. Martin, Jr., Esq.
Email: bmartin@cochranfirm.com

BFM/ws

Enclosures

THE COCHRAN FIRM
MEMPHIS

ONE COMMERCE SQUARE • 26TH FLOOR • MEMPHIS, TENNESSEE 38103
(901) 523-1222 • FAX: (901) 523-1999
WWW.COCHRANFIRM.COM

December 17, 2009

TN19156

Timothy L. Kemp, M.D.
South Emergency Associates/
Baptist Collierville Hospital
1500 West Poplar
Collierville, Tennessee 38017

VIA CERTIFIED MAIL

RE: Jessie Mae Snow, Deceased
Notice Required by T.C.A. § 29-26-121 (a)

Dear Dr. Kemp:

I am the attorney representing Jessie Mae Snow, Deceased and Anthony Snow, Jr., Husband. Through me and my firm, Anthony Snow, Jr. is asserting a potential claim for medical malpractice against you. This claim arises out of care provided by you to your patient, Jessie Mae Snow, Deceased at Baptist Memorial Hospital – Collierville during her admission beginning on/about January 2, 2009.

The full name and date of birth of the patient whose treatment is at issue are:

Jessie Mae Snow, Deceased
Date of Birth: November 13, 1974

The name and address of the claimant authorizing this notice and relationship to the patient are:

Anthony Snow, Jr., Husband
140 Jordon Road
Holly Springs, Mississippi 38635

The name and address of the attorney sending this notice are:

Bobby F. Martin, Jr., Esq.
The Cochran Firm – Memphis
One Commerce Square, 26th Floor
Memphis, Tennessee 38103

Enclosed herein is a list of the names and addresses of all providers being sent a notice.

Enclosed are HIPAA compliant medical authorizations permitting you to obtain complete medical records from each other provider being sent a notice.

Please forward this correspondence and all enclosures to your professional liability insurance carrier and/or your legal counsel. I would also like to invite you to contact me for the purpose of giving a sworn statement detailing the care that you provided to my client. Please ask your representative (either a representative from your professional liability insurance carrier or your legal counsel) to contact me for the purpose of scheduling an appointment.

Thank you.

Sincerely,

THE COCHRAN FIRM – MEMPHIS

Bobby F. Martin, Jr., Esq.
Email: bmartin@cochranfirm.com

BFM/ws

Enclosures

THE COCHRAN FIRM
MEMPHIS

ONE COMMERCE SQUARE • 26TH FLOOR • MEMPHIS, TENNESSEE 38103
(901) 523-1222 • FAX: (901) 523-1999
WWW.COCHRANFIRM.COM

December 17, 2009

TN19156

South Emergency Associates, P.C.
8596 Rockcreek Parkway
Cordova, Tennessee 38016

VIA CERTIFIED MAIL

RE: Jessie Mae Snow, Deceased
Notice Required by T.C.A. § 29-26-121 (a)

Dear South Emergency Associates, P.C.:

I am the attorney representing Jessie Mae Snow, Deceased and Anthony Snow, Jr., Husband. Through me and my firm, Anthony Snow, Jr. is asserting a potential claim for medical malpractice against your professional corporation. This claim arises out of care provided by employees, shareholders, members, agents, of South Emergency Associates, P.C. and by other individuals acting on behalf of South Emergency Associates, P.C. all of whom provided care to and/or on behalf of South Emergency Associates, P.C.'s patient, Jessie Mae Snow, Deceased while Jessie Mae Snow, Deceased received care and attention by or on behalf of South Emergency Associates, P.C. at Baptist Memorial Hospital - Collierville, 1500 West Poplar, Collierville, Tennessee during her admission beginning on/about January 2, 2009.

The full name and date of birth of the patient whose treatment is at issue are:

Jessie Mae Snow, Deceased
Date of Birth: November 13, 1974

The name and address of the claimant authorizing this notice and relationship to the patient are:

Anthony Snow, Jr., Husband
140 Jordon Road
Holly Springs, Mississippi 38103

TENNESSEE LICENSED ATTORNEYS
JOHNNIE L. COCHRAN, JR.
(1937-2005)
SAMUEL A. CHERRY, JR. [4,5]
JOCK M. SMITH [1,2,6]
DONALD W. BUCKLER [4]
H. SCOTT BATES [4]
KEITH R. MITNIK [4]
ALEXANDER M. CLEM [4]
DAVID A. MCLAUGHLIN [2]
DANESE K. BANKS
W. BRYAN SMITH
GARRY J. RHODEN [4,5,7]
BOBBY F. MARTIN, JR. [2,5]
BILL M. WADE [2]
PETER B. GEE, JR. [2,5]
MARK A. LAMBERT [5]

ALSO ADMITTED IN:
[1] *ALABAMA*
[2] *ARKANSAS*
[3] *DISTRICT OF COLUMBIA*
[4] *FLORIDA*
[5] *MISSISSIPPI*
[6] *NEW YORK*
[7] *KENTUCKY*

The name and address of the attorney sending this notice are:

Bobby F. Martin, Jr., Esq.
The Cochran Firm - Memphis
One Commerce Square, 26th Floor
Memphis, Tennessee 38103

Enclosed herein is a list of the names and addresses of all providers being sent a notice.

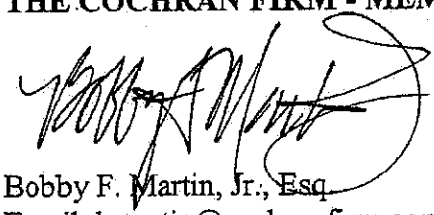
Enclosed are HIPAA compliant medical authorizations permitting your corporation to obtain complete medical records from each other provider being sent a notice.

Please send a copy of this correspondence and all enclosures to your professional liability insurance carrier and/or your legal counsel. I would appreciate hearing from your representative of your professional liability insurance carrier or your legal counsel as soon as possible.

Thank you.

Sincerely,

THE COCHRAN FIRM - MEMPHIS



Bobby F. Martin, Jr., Esq.
Email: bmartin@cochranfirm.com

BFM/ws

Enclosures

THE COCHRAN FIRM
MEMPHIS

ONE COMMERCE SQUARE • 26TH FLOOR • MEMPHIS, TENNESSEE 38103
(901) 523-1222 • FAX: (901) 523-1999
WWW.COCHRANFIRM.COM

December 17, 2009

TN19156

Frank J. Adcock, III, M.D.
Registered Agent for South Emergency
Associates, P.C.
8596 Rockcreek Parkway
Cordova, Tennessee 38016

VIA CERTIFIED MAIL

RE: Jessie Mae Snow, Deceased
Notice Required by T.C.A. § 29-26-121 (a)
South Emergency Associates, P.C.

Dear Dr. Adcock:

You are listed with the State of Tennessee as the agent for service of process for South Emergency Associates, P.C.

I am the attorney representing Jessie Mae Snow, Deceased and Anthony Snow, Jr., Husband. Through me and my firm, Anthony Snow, Jr. is asserting a potential claim for medical malpractice against South Emergency Associates, P.C. This claim arises out of care provided by South Emergency Associates, P.C. to the patient, Jessie Mae Snow, Deceased at Baptist Memorial Hospital - Collierville, in Collierville, Tennessee, during her admission beginning on/about January 2, 2009.

The full name and date of birth of the patient whose treatment is at issue are:

Jessie Mae Snow, Deceased
Date of Birth: November 13, 1974

The name and address of the claimant authorizing this notice and relationship to the patient are:

Anthony Snow, Jr., Husband
140 Jordon Road
Holly Springs, Mississippi 38103

The name and address of the attorney sending this notice are:

Bobby F. Martin, Jr., Esq.
The Cochran Firm - Memphis
One Commerce Square, 26th Floor
Memphis, Tennessee 38103

Enclosed herein is a list of the names and addresses of all providers being sent a notice.

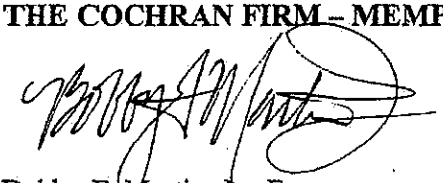
Enclosed are HIPAA compliant medical authorizations permitting South Emergency Associates, P.C. to obtain complete medical records from each other provider being sent a notice.

Please forward this correspondence to the appropriate individuals at South Emergency Associates, P.C. and to the professional liability insurance carrier and/or legal counsel of South Emergency Associates, P.C. Please ask a representative of the professional liability insurance carrier insuring South Emergency Associates, P.C. for this claim, and/or legal counsel, to contact me.

Thank you.

Sincerely,

THE COCHRAN FIRM – MEMPHIS



Bobby F. Martin, Jr., Esq.
Email: bmartin@cochranfirm.com

BFM/ws

Enclosures

LIST OF NAMES AND ADDRESSES OF ALL PROVIDERS BEING SENT A NOTICE PURSUANT TO T.C.A. § 29-26-121(a)

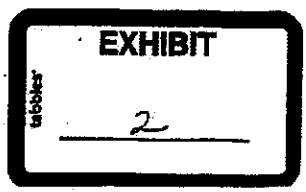
RE: Jessie Mae Snow, Deceased

The below is a list of health care providers to whom notice is being given, pursuant to T.CA. § 29-26-121(a), of a potential claim for medical malpractice:

1. Baptist Memorial Hospital - Collierville
   1500 West Poplar
   Collierville, Tennessee 38017

2. Timothy L. Kemp, M.D.
   South Emergency Associates/Baptist Collierville Hospital
   1500 West Poplar
   Collierville, Tennessee 38017

3. South Emergency Associates, P.C.
   8596 Rockcreek Parkway
   Cordova, Tennessee 38016



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Jessie Mae Snow	11/13/74	

Provider's/Health Plan's Name:	Recipient's Name:
Timothy L. Kemp, M.D.	Baptist Memorial Hospital-Collierville

Provider's/Health Plan's Address:	Address 1:		
South Emergency Associates/ Baptist Collierville Hospital 1500 West Poplar Collierville, TN 38017	1500 West Poplar		
	Address 2:		
	City: Collierville	State: TN	Zip: 38017

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 12/17/09
Print Name of Patient/Plan Member's Representative: Anthony Snow	Relationship to Patient/Plan Member: Husband

Revised 3/2003

EXHIBIT
tabbies
3

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Jessie Mae Snow	11/13/74	

Provider's/Health Plan's Name:	Recipient's Name:
South Emergency Associates, P.C.	Baptist Memorial Hospital-Collierville
Provider's/Health Plan's Address: 8596 Rockcreek Parkway Cordova, TN 38016	Address 1: 1500 West Poplar
	Address 2:
	City: Collierville State: TN Zip: 38017

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 12/17/09
Print Name of Patient/Plan Member's Representative: Anthony Snow	Relationship to Patient/Plan Member: Husband

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Jessie Mac Snow	Birth Date: 11/13/74	Social Security No. (optional):
Provider's/Health Plan's Name: Baptist Memorial Hospital-Collierville	Recipient's Name: Timothy L. Kemp, M.D.	
Provider's/Health Plan's Address: 1500 West Poplar Collierville, TN 38017	Address 1: South Emergency Associates/Baptist Collierville Hospital	
	Address 2: 1500 West Poplar	
	City: Collierville	State: TN Zip: 38017

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: [signature]	Date: 12/17/09
Print Name of Patient/Plan Member's Representative: [signature]	Relationship to Patient/Plan Member: husband

Revised 3/2003

EXHIBIT 4

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Jessie Mae Snow	11/13/74	

Provider's/Health Plan's Name:	Recipient's Name:
South Emergency Associates, P.C.	Timothy L. Kemp, M.D.
Provider's/Health Plan's Address: 8596 Rockcreek Parkway Cordova, TN 38016	Address 1: South Emergency Associates/Baptist Collierville Hospital
	Address 2: 1500 West Poplar
	City: Collierville / State: TN / Zip: 38017

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 12/17/09
Print Name of Patient/Plan Member's Representative: Jonathan V. Snow	Relationship to Patient/Plan Member: Husband

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Jessie Mae Snow	11/13/74	

Provider's/Health Plan's Name:	Recipient's Name:
Baptist Memorial Hospital-Collierville	South Emergency Associates, P.C.
Provider's/Health Plan's Address: 1500 West Poplar Collierville, TN 38017	Address 1: 8596 Rockcreek Parkway
	Address 2:
	City: Cordova State: TN Zip: 38016

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 12/17/09
Print Name of Patient/Plan Member's Representative: Anthony Snow	Relationship to Patient/Plan Member: Husband

Revised 3/2003

EXHIBIT
tabbies
5

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Jessie Mac Snow	11/13/74	

Provider's/Health Plan's Name:	Recipient's Name:
Timothy L. Kemp, M.D.	South Emergency Associates, P.C.

Provider's/Health Plan's Address:	Address 1:		
South Emergency Associates Baptist Collierville Hospital 1500 West Poplar Collierville, TN 38017	8596 Rockcreek Parkway		
	Address 2:		
	City: Cordova	State: TN	Zip: 38016

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films. x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
[signature]	12/17/09
Print Name of Patient/Plan Member's Representative: Jonathan V. Snow	Relationship to Patient/Plan Member: Husband

Revised 3/2003

BFM - TN19156

Name and Address of Sender
The Cochran Firm - Memphis
One Commerce Square, 26th Floor
Memphis, TN 38103

Check type of mail or service:
- [x] Certified
- [ ] COD
- [ ] Delivery Confirmation
- [ ] Express Mail
- [ ] Insured
- [ ] Recorded Delivery (International)
- [ ] Registered
- [x] Return Receipt for Merchandise
- [ ] Signature Confirmation

Affix Stamp Here (If issued as a certificate of mailing, or for additional copies of this bill)
Postmark and Date of Receipt

EXHIBIT tabbies 6

Article Number	Addressee (Name, Street, City, State, & ZIP Code)	Postage	Fee	Handling Charge	Actual Value If Registered	Insured Value	Due Sender If COD	DC Fee	SC Fee	SH Fee	RD Fee	RR Fee
1. 7008 2810 0000 5390 5509	Baptist Memorial Hospital-Collierville Mr. Glenn F. Baker, Administrator & Chief Executive Officer 1500 West Poplar Collierville, TN 38017											
2. 7008 2810 0000 5390 5516	Mr. Greg Duckett Registered Agent for Baptist Memorial Hospital-Collierville 350 North Humphreys Boulevard Memphis, TN 38120											
3. 7008 2810 0000 5390 5523	Timothy L. Kemp, M.D. South Emergency Associates/Baptist Collierville Hospital 1500 West Poplar Collierville, TN 38017											
4. 7008 2810 0000 5390 5530	South Emergency Associates, P.C. 8596 Rockcreek Parkway Cordova, TN 38016											
5. 7008 2810 0000 5390 5547	Frank J. Adcock, III, M.D. Registered Agent for South Emergency Associates P.C. 8596 Rockcreek Parkway Cordova, TN 38016											
6.												
7.												
8.												

Hasler
12/17/2009
US POSTAGE $02.20⁰
UNIT MEMPHIS
ZIP 38103
011D11606496

Delivery Confirmation
Insurance Coverage
Special Handling
Restricted Delivery
Return Receipt

Total Number of Pieces Listed by Sender	Total Number of Pieces Received at Post Office	Postmaster, Per (Name of receiving employee)
5	5	

See Privacy Act Statement on Reverse

PS Form 3877, February 2002 (Page 1 of 2) Complete by Typewriter, Ink, or Ball Point Pen

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits. TN19156

1. Article Addressed to:

Baptist Memorial Hospital - Collierville
Mr. Glenn F. Baker, Administrator and Chief Executive Officer
1500 West Poplar
Collierville, Tennessee 38017

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Ronnie Dixon ☒ Agent ☐ Addressee

B. Received by (Printed Name) Ronnie Dixon C. Date of Delivery 12-18

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7008 2810 0000 5390 5509

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

EXHIBIT
tabbies
7

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits. TN19156

1. Article Addressed to:

Timothy L. Kemp, M.D.
South Emergency Associates/
Baptist Collierville Hospital
1500 West Poplar
Collierville, Tennessee 38017

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Ronnie Dixon ☒ Agent ☐ Addressee

B. Received by (Printed Name) Ronnie Dixon C. Date of Delivery 12-9-09

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7008 2810 0000 5390 5523

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits. TN19156

1. Article Addressed to:

Mr. Greg Duckett
Registered Agent for Baptist Memorial Hospital-Collierville
350 North Humphreys Boulevard
Memphis, Tennessee 38120

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Vernita Townsend ☑ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 12-21-09

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7008 2810 0000 5390 5516

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits. TN19156

1. Article Addressed to:

South Emergency Associates, P.C.
8596 Rockcreek Parkway
Cordova, Tennessee 38016

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☑ Agent ☐ Addressee

B. Received by (Printed Name) FRANK ADCOCK C. Date of Delivery 12-21-09

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7008 2810 0000 5390 5530

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits. TN19156

1. Article Addressed to:

Frank J. Adcock, III, M.D.
Registered Agent for South Emergency Associates, P.C.
8596 Rockcreek Parkway
Cordova, Tennessee 38016

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☑ Agent ☐ Addressee

B. Received by (Printed Name) FRANK ADCOCK C. Date of Delivery 12-21-09

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☑ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7008 2810 0000 5390 5547

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

STATE OF TENNESSEE)
)
COUNTY OF SHELBY)

Comes now the Affiant, Wendy Sorrels, who, having first been duly sworn, makes oath that the following statements are true:

1. My name is Wendy Sorrels. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.

2. On December 23, 2009, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of December 23, 2009, the below notices and all enclosures to Baptist Memorial Hospital – Collierville, Mr. Glenn F. Baker, Administrator and Chief Executive Officer at the address of 1500 West Poplar, Collierville, Tennessee 38017, Mr. Greg Duckett, Registered Agent for Baptist Memorial Hospital - Collierville, at the address of 350 North Humphreys Boulevard, Memphis, Tennessee 38120, Timothy L. Kemp, M.D. at the address of South Emergency Associates/Baptist Collierville Hospital, 1500 West Poplar, Collierville, Tennessee 38017, THMS West Tennessee MC, LLC at the address of 1900 Winston Road, Suite 300, Knoxville, Tennessee 37919, and Corporation Service Company, Registered Agent for THMS West Tennessee MC, LLC at the address of 2908 Poston Avenue, Nashville, Tennessee 37203 as required by T.C.A. § 29-26-121(a):

Exhibit 1, which is the notice letters.

Exhibit 2, which is the list of the names and addresses of all providers who were being sent a notice pursuant to T.C.A. § 29-26-121 (a).

Exhibit 3, which is HIPAA compliant medical authorizations permitting Baptist Memorial Hospital – Collierville to obtain complete medical records from providers Timothy L. Kemp, M.D. and THMS West Tennessee MC, LLC who were sent a notice.

Exhibit 4, which is HIPAA compliant medical authorizations permitting Timothy L. Kemp, M.D. to obtain complete medical records from providers Baptist Memorial Hospital – Collierville and THMS West Tennessee MC, LLC who were sent a notice.

Exhibit 5, which is HIPAA compliant medical authorizations permitting THMS West Tennessee MC, LLC to obtain complete medical records from providers Baptist Memorial Hospital – Collierville and Timothy L. Kemp, M.D. who were sent a notice.

Exhibit 6, which is copies of the Certificate of Mailings from the U.S. Postal Service, stamped with the date of mailing.

Exhibit 7, which is copies of the return receipt cards that accompanied the notice letters sent by certified mail.

Wendy Sonela
SIGNATURE

Date: 12/23/09

Subscribed and sworn to before me this 23rd day of December, 2009.

SHEILA E. BOYER STATE OF TENNESSEE NOTARY PUBLIC COUNTY OF SHELBY

Sheila E Boyer
NOTARY PUBLIC

My commission expires: MY COMMISSION EXPIRES OCTOBER 26, 2011

THE COCHRAN FIRM
MEMPHIS

ONE COMMERCE SQUARE • 26TH FLOOR • MEMPHIS, TENNESSEE 38103
(901) 523-1222 • FAX: (901) 523-1999
WWW.COCHRANFIRM.COM

December 23, 2009

TN19156

Baptist Memorial Hospital - Collierville
Mr. Glenn F. Baker, Administrator and
Chief Executive Officer
1500 West Poplar
Collierville, Tennessee 38017

VIA CERTIFIED MAIL

RE: Jessie Mae Snow, Deceased
Notice Required by T.C.A. § 29-26-121 (a)

Dear Mr. Baker:

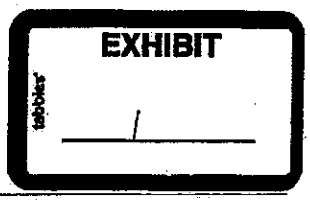
I am the attorney representing Jessie Mae Snow, Deceased and Anthony Snow, Jr., Husband. Through me and my firm, Anthony Snow, Jr. is asserting a potential claim for medical malpractice against your hospital. This claim arises out of care provided by employees and/or agents of your hospital, to, and/or on behalf of, the hospital's patient, Jessie Mae Snow, Deceased, while Jessie Mae Snow, Deceased was at your hospital at 1500 West Poplar, Collierville, Tennessee 38017 during her admission beginning on/about January 2, 2009.

The full name and date of birth of the patient whose treatment is at issue are:

Jessie Mae Snow, Deceased
Date of Birth: November 13, 1974

The name and address of the claimant authorizing this notice and relationship to the patient are:

Anthony Snow, Jr., Husband
140 Jordon Road
Holly Springs, Mississippi 38635



The name and address of the attorney sending this notice are:

Bobby F. Martin, Jr., Esq.
The Cochran Firm - Memphis
One Commerce Square, 26th Floor
Memphis, Tennessee 38103

Enclosed herein is a list of the names and addresses of all providers being sent a notice.

Enclosed are HIPAA compliant medical authorizations permitting your hospital to obtain complete medical records from each other provider being sent a notice.

I know that you will send a copy of this correspondence and all enclosures to your professional liability insurance carrier and/or your risk manager and/or your legal counsel. You are welcome to contact me, or your representative is welcome to contact me. I would appreciate hearing from someone about this matter as soon as possible.

Thank you very much.

Sincerely,

THE COCHRAN FIRM - MEMPHIS

Bobby F. Martin, Jr., Esq.
Email: bmartin@cochranfirm.com

BFM/ws

Enclosures

THE COCHRAN FIRM
MEMPHIS

ONE COMMERCE SQUARE • 26TH FLOOR • MEMPHIS, TENNESSEE 38103
(901) 523-1222 • FAX: (901) 523-1999
WWW.COCHRANFIRM.COM

December 23, 2009

TN19156

Mr. Greg Duckett
Registered Agent for Baptist Memorial
Hospital - Collierville
350 North Humphreys Boulevard
Memphis, Tennessee 38120

VIA CERTIFIED MAIL

RE: Jessie Mae Snow, Deceased
Notice Required by T.C.A. § 29-26-121 (a)
Baptist Memorial Hospital - Collierville

Dear Mr. Duckett:

You are listed with the State of Tennessee as the agent for service of process for Baptist Memorial Hospital - Collierville.

I am the attorney representing Jessie Mae Snow, Deceased and Anthony Snow, Jr., Husband. Through me and my firm, Anthony Snow, Jr. is asserting a potential claim for medical malpractice against Baptist Memorial Hospital - Collierville. This claim arises out of care provided by Baptist Memorial Hospital – Collierville to the patient, Jessie Mae Snow, Deceased, at Baptist Memorial Hospital - Collierville, 1500 West Poplar, Collierville, Tennessee 38017 during her admission beginning on/about January 2, 2009.

The full name and date of birth of the patient whose treatment is at issue are:

Jessie Mae Snow, Deceased
Date of Birth: November 13, 1974

The name and address of the claimant authorizing this notice and relationship to the patient are:

Anthony Snow, Jr., Husband
140 Jordon Road
Holly Springs, Mississippi 38635

The name and address of the attorney sending this notice are:

Bobby F. Martin, Jr., Esq.
The Cochran Firm - Memphis
One Commerce Square, 26th Floor
Memphis, Tennessee 38103

Enclosed herein is a list of the names and addresses of all providers being sent a notice.

Enclosed are HIPAA compliant medical authorizations permitting Baptist Memorial Hospital – Collierville to obtain complete medical records from each other provider being sent a notice.

Please forward this correspondence to the appropriate individuals at Baptist Memorial Hospital – Collierville to the professional liability insurance carrier and/or legal counsel of Baptist Memorial Hospital - Collierville. Please ask a representative of the professional liability insurance carrier insuring Baptist Memorial Hospital – Collierville for this claim, and/or legal counsel, to contact me.

Thank you.

Sincerely,

THE COCHRAN FIRM – MEMPHIS

Bobby F. Martin, Jr., Esq.
Email: bmartin@cochranfirm.com

BFM/ws

Enclosures

THE COCHRAN FIRM
MEMPHIS

ONE COMMERCE SQUARE • 26TH FLOOR • MEMPHIS, TENNESSEE 38103
(901) 523-1222 • FAX: (901) 523-1999
WWW.COCHRANFIRM.COM

December 23, 2009

TN19156

Timothy L. Kemp, M.D.
South Emergency Associates/
Baptist Collierville Hospital
1500 West Poplar
Collierville, Tennessee 38017

VIA CERTIFIED MAIL

RE: Jessie Mae Snow, Deceased
Notice Required by T.C.A. § 29-26-121 (a)

Dear Dr. Kemp:

I am the attorney representing Jessie Mae Snow, Deceased and Anthony Snow, Jr., Husband. Through me and my firm, Anthony Snow, Jr. is asserting a potential claim for medical malpractice against you. This claim arises out of care provided by you to your patient, Jessie Mae Snow, Deceased at Baptist Memorial Hospital – Collierville during her admission beginning on/about January 2, 2009.

The full name and date of birth of the patient whose treatment is at issue are:

Jessie Mae Snow, Deceased
Date of Birth: November 13, 1974

The name and address of the claimant authorizing this notice and relationship to the patient are:

Anthony Snow, Jr., Husband
140 Jordon Road
Holly Springs, Mississippi 38635

The name and address of the attorney sending this notice are:

Bobby F. Martin, Jr., Esq.
The Cochran Firm – Memphis
One Commerce Square, 26th Floor
Memphis, Tennessee 38103

Enclosed herein is a list of the names and addresses of all providers being sent a notice.

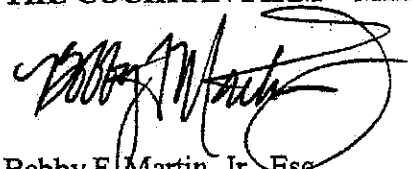
Enclosed are HIPAA compliant medical authorizations permitting you to obtain complete medical records from each other provider being sent a notice.

Please forward this correspondence and all enclosures to your professional liability insurance carrier and/or your legal counsel. I would also like to invite you to contact me for the purpose of giving a sworn statement detailing the care that you provided to my client. Please ask your representative (either a representative from your professional liability insurance carrier or your legal counsel) to contact me for the purpose of scheduling an appointment.

Thank you.

Sincerely,

THE COCHRAN FIRM – MEMPHIS



Bobby F. Martin, Jr., Esq.
Email: bmartin@cochranfirm.com

BFM/ws

Enclosures

THE COCHRAN FIRM
MEMPHIS

ONE COMMERCE SQUARE • 26TH FLOOR • MEMPHIS, TENNESSEE 38103
(901) 523-1222 • FAX: (901) 523-1999
WWW.COCHRANFIRM.COM

December 23, 2009

TN19156

THMS West Tennessee MC, LLC
1900 Winston Road, Suite 300
Knoxville, Tennessee 37919

VIA CERTIFIED MAIL

RE: Jessie Mae Snow, Deceased
Notice Required by T.C.A. § 29-26-121 (a)

Dear THMS West Tennessee MC, LLC:

I am the attorney representing Jessie Mae Snow, Deceased and Anthony Snow, Jr., Husband. Through me and my firm, Anthony Snow, Jr. is asserting a potential claim for medical malpractice against your professional corporation. This claim arises out of care provided by employees, shareholders, members, agents, of THMS West Tennessee MC, LLC and by other individuals acting on behalf of THMS West Tennessee MC, LLC all of whom provided care to and/or on behalf of THMS West Tennessee MC, LLC's patient, Jessie Mae Snow, Deceased while Jessie Mae Snow, Deceased received care and attention by or on behalf of THMS West Tennessee MC, LLC at Baptist Memorial Hospital - Collierville, 1500 West Poplar, Collierville, Tennessee during her admission beginning on/about January 2, 2009.

The full name and date of birth of the patient whose treatment is at issue are:

Jessie Mae Snow, Deceased
Date of Birth: November 13, 1974

The name and address of the claimant authorizing this notice and relationship to the patient are:

Anthony Snow, Jr., Husband
140 Jordon Road
Holly Springs, Mississippi 38103

The name and address of the attorney sending this notice are:

Bobby F. Martin, Jr., Esq.
The Cochran Firm - Memphis
One Commerce Square, 26th Floor
Memphis, Tennessee 38103

Enclosed herein is a list of the names and addresses of all providers being sent a notice.

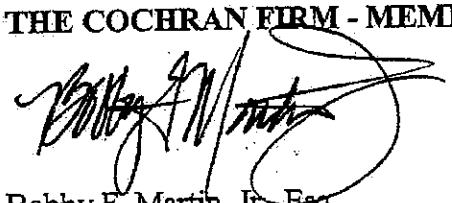
Enclosed are HIPAA compliant medical authorizations permitting your corporation to obtain complete medical records from each other provider being sent a notice.

Please send a copy of this correspondence and all enclosures to your professional liability insurance carrier and/or your legal counsel. I would appreciate hearing from your representative of your professional liability insurance carrier or your legal counsel as soon as possible.

Thank you.

Sincerely,

THE COCHRAN FIRM - MEMPHIS



Bobby F. Martin, Jr., Esq.
Email: bmartin@cochranfirm.com

BFM/ws

Enclosures

THE COCHRAN FIRM
MEMPHIS

ONE COMMERCE SQUARE • 26TH FLOOR • MEMPHIS, TENNESSEE 38103
(901) 523-1222 • FAX: (901) 523-1999
WWW.COCHRANFIRM.COM

December 23, 2009

TN19156

Corporation Service Company
Registered Agent for THMS West
Tennessee MC, LLC
2908 Poston Avenue
Nashville, Tennessee 37203

VIA CERTIFIED MAIL

RE: Jessie Mae Snow, Deceased
Notice Required by T.C.A. § 29-26-121 (a)
THMS West Tennessee MC, LLC

Dear Corporation Service Company:

You are listed with the State of Tennessee as the agent for service of process for THMS West Tennessee MC, LLC.

I am the attorney representing Jessie Mae Snow, Deceased and Anthony Snow, Jr., Husband. Through me and my firm, Anthony Snow, Jr. is asserting a potential claim for medical malpractice against THMS West Tennessee MC, LLC. This claim arises out of care provided by THMS West Tennessee MC, LLC to the patient, Jessie Mae Snow, Deceased at Baptist Memorial Hospital - Collierville, in Collierville, Tennessee, during her admission beginning on/about January 2, 2009.

The full name and date of birth of the patient whose treatment is at issue are:

Jessie Mae Snow, Deceased
Date of Birth: November 13, 1974

The name and address of the claimant authorizing this notice and relationship to the patient are:

Anthony Snow, Jr., Husband
140 Jordon Road
Holly Springs, Mississippi 38103

The name and address of the attorney sending this notice are:

Bobby F. Martin, Jr., Esq.
The Cochran Firm - Memphis
One Commerce Square, 26th Floor
Memphis, Tennessee 38103

Enclosed herein is a list of the names and addresses of all providers being sent a notice.

Enclosed are HIPAA compliant medical authorizations permitting THMS West Tennessee MC, LLC to obtain complete medical records from each other provider being sent a notice.

Please forward this correspondence to the appropriate individuals at THMS West Tennessee MC, LLC and to the professional liability insurance carrier and/or legal counsel of THMS West Tennessee MC, LLC. Please ask a representative of the professional liability insurance carrier insuring THMS West Tennessee MC, LLC for this claim, and/or legal counsel, to contact me.

Thank you.

Sincerely,

THE COCHRAN FIRM – MEMPHIS

Bobby F. Martin, Jr., Esq.
Email: bmartin@cochranfirm.com

BFM/ws

Enclosures

LIST OF NAMES AND ADDRESSES OF ALL PROVIDERS BEING SENT A NOTICE PURSUANT TO T.C.A. § 29-26-121(a)

RE: Jessie Mae Snow, Deceased

The below is a list of health care providers to whom notice is being given, pursuant to T.CA. § 29-26-121(a), of a potential claim for medical malpractice:

1. Baptist Memorial Hospital - Collierville
   1500 West Poplar
   Collierville, Tennessee 38017

2. Timothy L. Kemp, M.D.
   South Emergency Associates/Baptist Collierville Hospital
   1500 West Poplar
   Collierville, Tennessee 38017

3. THMS West Tennessee MC, LLC
   1900 Winston Road, Suite 300
   Knoxville, Tennessee 37919

EXHIBIT
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2

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Jessie Mac Snow	11/13/74	

Provider's/Health Plan's Name:	Recipient's Name:
Timothy L. Kemp, M.D.	Baptist Memorial Hospital-Collierville

Provider's/Health Plan's Address:	Address 1:		
South Emergency Associates/ Baptist Collierville Hospital 1500 West Poplar Collierville, TN 38017	1500 West Poplar		
	Address 2:		
	City: Collierville	State: TN	Zip: 38017

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 12/23/09
Print Name of Patient/Plan Member's Representative:	Relationship to Patient/Plan Member: Husband

Revised 3/2003

EXHIBIT 3

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Jessie Mac Snow	Birth Date: 11/13/74	Social Security No. (optional):
Provider's/Health Plan's Name: THMS West Tennessee MC, LLC	Recipient's Name: Baptist Memorial Hospital-Collierville	
Provider's/Health Plan's Address: 1900 Winston Road, Suite 300 Knoxville, TN 37919	Address 1: 1500 West Poplar Address 2:	
	City: Collierville	State: TN Zip: 38017

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ BR Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 12/23/09
Print Name of Patient/Plan Member's Representative:	Relationship to Patient/Plan Member: Husband

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Jessie Mae Snow	11/13/74	

Provider's/Health Plan's Name:	Recipient's Name:
Baptist Memorial Hospital-Collierville	Timothy L. Kemp, M.D.
Provider's/Health Plan's Address: 1500 West Poplar Collierville, TN 38017	Address 1: South Emergency Associates/ Baptist Collierville Hospital
	Address 2: 1500 West Poplar
	City: Collierville / State: TN / Zip: 38017

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 12/23/09
Print Name of Patient/Plan Member's Representative: Jonathan V. Snow	Relationship to Patient/Plan Member: Husband

Revised 3/2003

EXHIBIT
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Jessie Mae Snow	11/13/74	

Provider's/Health Plan's Name:	Recipient's Name:
THMS West Tennessee MC, LLC	Timothy L. Kemp, M.D.
Provider's/Health Plan's Address: 1900 Winston Road, Suite 300 Knoxville, TN 37919	Address 1: South Emergency Associates/ Baptist Collierville Hospital
	Address 2: 1500 West Poplar
	City: Collierville / State: TN / Zip: 38017

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Anthony Snow	12/23/09
Print Name of Patient/Plan Member's Representative: Anthony Snow	Relationship to Patient/Plan Member: Husband

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Jessie Mae Snow	11/13/74	

Provider's/Health Plan's Name:	Recipient's Name:
Baptist Memorial Hospital - Collierville	THMS West Tennessee MC, LLC

Provider's/Health Plan's Address:	Address 1:		
1500 West Poplar Collierville, TN 38017	1900 Winston Road, Suite 300		
	Address 2:		
	City: Knoxville	State: TN	Zip: 37919

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES *NOT* PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Anthony Snow	12/23/09
Print Name of Patient/Plan Member's Representative: Anthony Snow	Relationship to Patient/Plan Member: Husband

Revised 3/2003

EXHIBIT
tabbies
5

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Jessie Mae Snow	11/13/74	

Provider's/Health Plan's Name:	Recipient's Name:
Timothy L. Kemp, M.D.	THMS West Tennessee MC, LLC

Provider's/Health Plan's Address:	Address 1:		
South Emergency Associates/ Baptist Collierville Hospital 1500 West Poplar Collierville, TN38017	1900 Winston Road, Suite 300		
	Address 2:		
	City: Knoxville	State: TN	Zip: 37919

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing information ☐ Transfer forms ☐ ER information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
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Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 12/23/09
Print Name of Patient/Plan Member's Representative: Anthony Snow	Relationship to Patient/Plan Member: Husband

Revised 3/2003

BFM - TN19156

Name and Address of Sender
The Cochran Firm-Memphis
One Commerce Square, 26th Floor
Memphis, TN 38103

Check type of mail or service:
- [x] Certified
- [ ] COD
- [ ] Delivery Confirmation
- [ ] Express Mail
- [ ] Insured
- [ ] Recorded Delivery (International)
- [ ] Registered
- [x] Return Receipt for Merchandise
- [ ] Signature Confirmation

Affix Stamp Here
(If issued as a certificate of mailing, or for additional copies of this bill)
Postmark and Date of Receipt

EXHIBIT
tabbies 6

Article Number	Addressee (Name, Street, City, State, & ZIP Code)	Postage	Fee	Handling Charge	Actual Value if Registered	Insured Value	Due Sender if COD	DC Fee	SC Fee	SH Fee	RD Fee	RR Fee
1. 7008 2810 0000 5390 5578	Baptist Memorial Hospital-Collierville Mr. Glenn F. Baker Administrator and Chief Executive Officer 1500 West Poplar Collierville, TN 38017											
2. 7008 2810 0000 5390 5585	Mr. Greg Duckett, Registered Agent for Baptist Memorial Hospital-Collierville 350 North Humphreys Boulevard Memphis, TN 38120											
3. 7008 2810 0000 5390 5592	Timothy L. Kemp, M.D. South Emergency Associates/Baptist Collierville Hospital 1500 West Poplar Collierville, TN 38017											
4. 7008 2810 0000 5390 5608	THMS West Tennessee MC, LLC 1900 Winston Road, Suite 300 Knoxville, TN 37919								Signature Confirmation	Special Handling	Restricted Delivery	Return Receipt
5. 7008 2810 0000 5390 5615	Corporation Service Company Registered Agent for THMS West Tennessee MC, LLC 2908 Poston Avenue Nashville, TN 37203							Delivery Confirmation				
6.												
7.												
8.												

Total Number of Pieces Listed by Sender	Total Number of Pieces Received at Post Office	Postmaster, Per (Name of receiving employee)
5	5	

See Privacy Act Statement on Reverse

PS Form 3877, February 2002 *(Page 1 of 2)* Complete by Typewriter, Ink, or Ball Point Pen

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits. TN19156

1. Article Addressed to:

Timothy L. Kemp, M.D.
South Emergency Associates/
Baptist Collierville Hospital
1500 West Poplar
Collierville, TN 38017

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Ronnie Dixon ☐ Agent ☐ Addressee

B. Received by (Printed Name) Ronnie Dixon C. Date of Delivery 12-28

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7008 2810 0000 5390 5592

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-154

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits. TN19156

1. Article Addressed to:

Baptist Memorial Hospital-
Collierville
Mr. Glenn F. Baker, Administrator
and Chief Executive Officer
1500 West Poplar
Collierville, Tennessee 38017

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Ronnie Dixon ☐ Agent ☐ Addressee

B. Received by (Printed Name) Ronnie Dixon C. Date of Delivery 12-28

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7008 2810 0000 5390 5578

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-154

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits. TN19156

1. Article Addressed to:

Mr. Greg Duckett
Registered Agent for Baptist
Memorial Hospital-Collierville
350 North Humphreys Boulevard
Memphis, Tennessee 38120

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Termite Treatment ☑ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 12-29-09

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7008 2810 0000 5390 5585

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-154

EXHIBIT
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SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits. TN19156

1. Article Addressed to:

THMS West Tennessee
MC, LLC
1900 Winston Road, Suite 300
Knoxville, Tennessee 37919

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) S BREWER C. Date of Delivery 12-28

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7008 2810 0000 5390 5608

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-154

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits. TN19156

1. Article Addressed to:

Corporation Service Company
Registered Agent for THMS
West Tennessee MC, LLC
2908 Poston Avenue
Nashville, TN 37203

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [illegible] C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

DEC 28 2009

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7008 2810 0000 5390 5615

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-154

IN THE CIRCUIT COURT OF TENNESSEE
FOR THE THIRTIETH JUDICIAL DISTRICT AT MEMPHIS, SHELBY COUNTY

ANTHONY SNOW, Individually and as Next of Kin of JESSIE M. SNOW, Deceased,

Plaintiff,

v.

TIMOTHY L. KEMP, M.D., THMS WEST TENNESSEE MC, LLC, and BAPTIST MEMORIAL HOSPITAL – COLLIERVILLE,

Defendants.

Div. __

Docket No. CT-_____

Jury Demanded

CERTIFICATE OF GOOD FAITH

Medical Malpractice Case

PLAINTIFF'S FORM

A. In accordance with T.C.A. § 29-26-122, I hereby state the following: (Check item 1 or 2 below and sign your name beneath the item you have checked, verifying the information you have checked. Failure to check item 1 or 2 and/or not signing item 1 or 2 will make this case subject to dismissal with prejudice.)

☐ 1. The Plaintiff or Plaintiff's counsel has consulted with one (1) or more experts who have provided a signed written statement confirming that upon information and belief they:

(A) Are competent under § 29-26-115 to express opinion(s) in the case; and

(B) Believe, based on the information available from the medical records concerning the care and treatment of the Plaintiff for the incident(s) at issue, that there is a good faith basis to maintain the action consistent with the requirements of § 29-26-115.

_____
Signature of Plaintiff if not represented, or Signature of Plaintiff's Counsel

or

EXHIBIT
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B

X 2. The Plaintiff or Plaintiff's counsel has consulted with one (1) or more experts who have provided a signed written statement confirming that upon information and belief they:

(A) Are competent under § 29-26-115 to express opinion(s) in the case; and

(B) Believe, based on the information available from the medical records reviewed concerning the care and treatment of the Plaintiff for the incident(s) at issue and, as appropriate, information from the Plaintiff or others with knowledge of the incident(s) at issue, that there are facts material to the resolution of the case that cannot be reasonably ascertained from the medical records or information reasonably available to the Plaintiff or Plaintiff's counsel; and that despite the absence of this information there is a good faith basis for maintaining the action as to each Defendant consistent with the requirements of § 29-26-115. Refusal of the Defendant to release the medical records in a timely fashion, or where it is impossible for the Plaintiff to obtain the medical records shall waive the requirement that the expert review the medical records prior to expert certification.

Signature of Plaintiff if not represented, or Signature of Plaintiff's Counsel

B. You MUST complete the information below and sign:

I have been found in violation of T.C.A. § 29-26-122 0 prior times. (Insert number of prior violations by you).

Signature of Person Executing This Document

4/22/10
Date

MISSISSIPPI STATE DEPARTMENT OF HEALTH
VITAL RECORDS

FILING DATE: JAN 09 2009

CERTIFICATE OF DEATH
STATE OF MISSISSIPPI

STATE FILE NUMBER: 123 2009-000014

1. NAME: First: JESSIE Middle: MAE Last: SNOW	2. SEX: FEMALE	3a. HOUR OF DEATH: 5:45 p.m.	3b. DATE OF DEATH (Month, Day, Year): JANUARY 3, 2009
4. RACE (Specify White, Black, American Indian, etc.): BLACK	5a. AGE AT LAST BIRTHDAY: 34 Years	5b. IF UNDER 1 YEAR: 5c. DAYS	5d. IF UNDER 1 DAY: 5e. MINS / 5d. HOURS	6. DATE OF BIRTH (Month, Day, Year): NOV. 13, 1974	7. STATE OF BIRTH: TENNESSEE

8. PLACE OF DEATH (Check only one box): IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA — IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice Facility ☐ Nursing Home/Long Term Care Facility ☐ Other (Specify)

8a. FACILITY NAME (If not a facility, give street address, room number, or rural location) (If hospital, also give ID number): 140 JORDON ROAD	9b. CITY, TOWN OR LOCATION OF DEATH: HOLLY SPRINGS	9c. COUNTY OF DEATH: MARSHALL	
10. DECEDENT'S EDUCATION (Specify only highest grade completed): Elem/High School (0-12): 12 College (1-4 or 5+): 4	11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED	12. SURVIVING SPOUSE (If wife, give maiden name): ANTHONY SNOW	13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No): NO
14. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes (Specify)	15. SOCIAL SECURITY NUMBER: 410-25-9853	16a. USUAL OCCUPATION (Kind of work done most of working life): TEACHER	16b. KIND OF BUSINESS OR INDUSTRY: HEADSTART
17a. RESIDENCE - STATE: MISSISSIPPI	17b. COUNTY: MARSHALL	17c. CITY OR TOWN: HOLLY SPRINGS	17d. INSIDE CITY LIMITS (Specify Yes or No): NO	17e. STREET AND NUMBER OR RURAL LOCATION: 140 JORDON ROAD
18. FATHER - NAME: First: JESSIE Middle: ROY Last: RUBIN	19. MOTHER - NAME: First: NAIOMA Middle: Maiden: DOTCH		
20a. INFORMANT - NAME (Type or print): ANTHONY SNOW	20b. RELATIONSHIP TO DECEDENT: SPOUSE	20c. MAILING ADDRESS (Street and number, City or town, State, ZIP Code): 140 JORDON RD., HOLLY SPRINGS, MS 38635	
21. DISPOSITION OF BODY (Specify Burial, Cremation, Removal, etc.): BURIAL	21b. CEMETERY/CREMATORY - NAME: PLEASANT HILL CME CHURCH CEMETERY	21c. LOCATION (City and State): MT. PLEASANT, MS	21d. EMBALMER - SIGNATURE AND LICENSE NUMBER: FS-461
22a. FUNERAL HOME - NAME: J. F. BRITTENUM & SON # 47B	22b. FUNERAL HOME LICENSE NUMBER: FE-212	22d. MAILING ADDRESS (Street and number, City or town, State, ZIP Code): 125 MEMPHIS ST., HOLLY SPRINGS, MS 38635	
23a. PERSON WHO PRONOUNCED DEATH - NAME AND TITLE (Type or print): JAMES R. ANDERSON, MARSHALL COUNTY MEI	23b. PRONOUNCED DEAD (Month, Day, Year): ON Jan. 3, 2009	23c. PRONOUNCED DEAD (Hour): AT 6:18 p.m.	
24a. CERTIFIER - NAME (Type or print): JAMES R. ANDERSON	24b. MAILING ADDRESS (Street and number, City or town, State, ZIP Code): P. O. BOX 5464, HOLLY SPRINGS, MS 38634-5464		

This section to be completed by Physician IF NOT a medical examiner:
25a. To the best of my knowledge, death occurred due to the cause(s) and manner as stated. SIGNATURE > MD
25b. DATE SIGNED (Month, Day, Year)
25c. STATE LICENSE NUMBER

This section to be completed by coroner or medical examiner ONLY:
25d. On the basis of examination, and/or investigation, in my opinion, death occurred due to the cause(s) and manner as stated. SIGNATURE > James R. Anderson
25e. TITLE: CME I
25f. DATE SIGNED (Month, Day, Year): Jan. 7 2009

25d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

CAUSE OF DEATH — 26. PART I - Enter the chain of medical - disease, injuries, or complications - that directly caused the death. DO NOT enter terminal events such as cardiac arrest, shock, or heart failure. Interval between onset and death

IMMEDIATE CAUSE (Final disease or condition resulting in death): (a) Sudden Pulmonary Thrombo-emboli

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST.
DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (b) Deep Venous Thrombosis, Left Lower Extremity
DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (c) Right Ventricular Dilatation of Heart
DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (d)

27. PART II: OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I.

28. AUTOPSY (Yes or No): Yes
29. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No): Yes

30. IF FEMALE, SPECIFY: ☐ Was not pregnant within the past year ☐ Not pregnant, but had been pregnant 43 days to 1 year before death. ☐ Was pregnant at the time of death. ☐ Unknown if pregnant within the past year. ☐ Not pregnant, but pregnant within 42 days of death.

Use If Death NOT due to natural causes:
31a. ACCIDENT, SUICIDE, HOMICIDE, PENDING INVESTIGATION, OR UNDETERMINED (Specify)
31b. DATE OF INJURY (Month, Day, Year)
31c. HOUR OF INJURY
31d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED
31e. INJURY AT WORK (Yes or No)
31f. PLACE OF INJURY (Specify: Home, Farm, Street, Factory, Office building, etc.)
31g. LOCATION: Street or route number | City or town | State

Mississippi State Department of Health — Revised 1-14-08 — Form 511

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE ON FILE IN THIS OFFICE

JAN 22 2009

Judy Moulder
STATE REGISTRAR

WARNING: A REPRODUCTION OF THIS DOCUMENT RENDERS IT VOID AND INVALID. DO NOT ACCEPT UNLESS EMBOSSED SEAL OF THE MISSISSIPPI STATE BOARD OF HEALTH IS PRESENT. IT IS ILLEGAL TO ALTER OR COUNTERFEIT THIS DOCUMENT.

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER. THIS IS WATERMARKED PAPER. DO NOT ACCEPT WITHOUT FIRST HOLDING

EXHIBIT
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C

(CIRCUIT/CHANCERY) COURT OF TENNESSEE
140 ADAMS AVENUE, MEMPHIS, TENNESSEE 38103
FOR THE THIRTIETH JUDICIAL DISTRICT AT MEMPHIS

SUMMONS IN CIVIL ACTION

Docket No. CT-002067-10

(•) Lawsuit
( ) Divorce

Ad Damnum $ _____

ANTHONY SNOW, Individually and as Next of Kin of JESSIE M. SNOW, Deceased,	VS	TIMOTHY L. KEMP, M.D., THMS WEST TENNESSEE MC, LLC, and BAPTIST MEMORIAL HOSPITAL - COLLIERVILLE,
Plaintiff(s)		Defendant(s)

TO: (Name and Address of Defendant (One defendant per summons))

THMS West Tennessee MC, LLC
c/o Corporation Service Company
2908 Poston Avenue
Nashville, TN 37203

Please serve upon registered agent for service of process.

Method of Service:

( ) Certified Mail
( ) Shelby County Sheriff
( ) Commissioner of Insurance ($)
( ) Secretary of State ($)
( ) Other TN County Sheriff ($)
(✓) Private Process Server
( ) Other

($) Attach Required Fees

You are hereby summoned and required to defend a civil action by filing your answer with the Clerk of the Court and serving a copy of your answer to the Complaint on Bobby F. Martin, Jr., Esq., The Cochran Firm - Memphis Plaintiff's attorney, whose address is One Commerce Square, 26th Floor, Memphis, TN 38103, telephone +1 (901) 217-7000 within THIRTY (30) DAYS after this summons has been served upon you, not including the day of service. If you fail to do so, a judgment by default may be taken against you for the relief demanded in the Complaint.

JIMMY MOORE Clerk

TESTED AND ISSUED April 22 2010 By _____ D.C.

TO THE DEFENDANT:

NOTICE; Pursuant to Chapter 919 of the Public Acts of 1980, you are hereby given the following notice:
Tennessee law provides a four thousand dollar ($4,000) personal property exemption from execution or seizure to satisfy a judgment. If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a written list, under oath, of the items you wish to claim as exempt with the Clerk of the Court. The list may be filed at any time and may be changed by you thereafter as necessary; however, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment issued prior to the filing of the list. Certain items are automatically exempt by law and do not need to be listed. These include items of necessary wearing apparel (clothing) for yourself and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Bible and school books. Should any of these items be seized, you would have the right to recover them. If you do not understand your exemption right or how to exercise it, you may wish to seek the counsel of a lawyer.

FOR AMERICANS WITH DISABILITIES ACT (ADA) ASSISTANCE ONLY, CALL (901) 379-7895

I, JIMMY MOORE, Clerk of the Court, Shelby County, Tennessee, certify this to be a true and accurate copy as filed this

_____

JIMMY MOORE, Clerk

By: _____, D.C.

RETURN OF SERVICE OF SUMMONS

I HEREBY CERTIFY THAT I **HAVE** SERVED THE WITHIN SUMMONS:

By delivering on the 26 day of April, 2010 at 11:46 AM. a copy of the summons and a copy of the Complaint to the following Defendant THMSWEST TENNESSEE MC, LLC c/o Corporation Service Company @2908 Poston Ave. Nashville, TN 37203 c/o Mary Moreschi (Reg. Agent)

Signature of person accepting service

By: Casey C. Ruff
~~Sheriff~~ or other authorized person to serve process

RETURN OF NON-SERVICE OF SUMMONS

I HEREBY CERTIFY THAT I **HAVE NOT** SERVED THE WITHIN SUMMONS:

To the named Defendant _____

because _____ is (are) not to be found in this County after diligent search and inquiry for the following reason(s): _____

This _____ day of _____, 20_____.

By: _____
Sheriff or other authorized person to serve process

Docket No: CT002067-10

IN THE
(CIRCUIT/CHANCERY) COURT

OF TENNESSEE
FOR THE
THIRTIETH JUDICIAL
DISCTRICT AT MEMPHIS

SUMMONS IN A CIVIL ACTION

ANTHONY SNOW/JESSIE M. SNOW, Decd
Plaintiff

VS

TIMOTHY L. KEMP, M.D., et al.
Defendant

Bobby F. Martin, Jr., Esq.
Attorney for Plaintiff/Pro Se

(901) 217-7000
Telephone Number

(CIRCUIT/CHANCERY) COURT OF TENNESSEE
140 ADAMS AVENUE, MEMPHIS, TENNESSEE 38103
FOR THE THIRTIETH JUDICIAL DISTRICT AT MEMPHIS

SUMMONS IN CIVIL ACTION

Docket No. CT-002067-10

(•) Lawsuit
( ) Divorce

Ad Damnum $ _____

ANTHONY SNOW, Individually and as Next of Kin of JESSIE M. SNOW, Deceased,	VS	TIMOTHY L. KEMP, M.D., THMS WEST TENNESSEE MC, LLC, and BAPTIST MEMORIAL HOSPITAL - COLLIERVILLE,
Plaintiff(s)		Defendant(s)

TO: (Name and Address of Defendant (One defendant per summons))

Baptist Memorial Hospital - Collierville
c/o Mr. Greg Duckett
350 North Humphreys Blvd.
Memphis, TN 38120-2177

Please serve upon registered agent for service of process.

Method of Service:

( ) Certified Mail
( ) Shelby County Sheriff
( ) Commissioner of Insurance ($)
( ) Secretary of State ($)
( ) Other TN County Sheriff ($)
(•) Private Process Server
( ) Other

($) Attach Required Fees

You are hereby summoned and required to defend a civil action by filing your answer with the Clerk of the Court and serving a copy of your answer to the Complaint on Bobby F. Martin, Jr., Esq., The Cochran Firm - Memphis Plaintiff's attorney, whose address is One Commerce Square, 26th Floor, Memphis, TN 38103, telephone +1 (901) 217-7000 within THIRTY (30) DAYS after this summons has been served upon you, not including the day of service. If you fail to do so, a judgment by default may be taken against you for the relief demanded in the Complaint.

JIMMY MOORE Clerk

TESTED AND ISSUED April 22 2010 By _____ D.C.

TO THE DEFENDANT:

NOTICE; Pursuant to Chapter 919 of the Public Acts of 1980, you are hereby given the following notice:
Tennessee law provides a four thousand dollar ($4,000) personal property exemption from execution or seizure to satisfy a judgment. If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a written list, under oath, of the items you wish to claim as exempt with the Clerk of the Court. The list may be filed at any time and may be changed by you thereafter as necessary; however, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment issued prior to the filing of the list. Certain items are automatically exempt by law and do not need to be listed. These include items of necessary wearing apparel (clothing) for yourself and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Bible and school books. Should any of these items be seized, you would have the right to recover them. If you do not understand your exemption right or how to exercise it, you may wish to seek the counsel of a lawyer.

FOR AMERICANS WITH DISABILITIES ACT (ADA) ASSISTANCE ONLY, CALL (901) 379-7895

I, JIMMY MOORE, Clerk of the Court, Shelby County, Tennessee, certify this to be a true and accurate copy as filed this

_____

JIMMY MOORE, Clerk

By: _____, D.C.

RETURN OF SERVICE OF SUMMONS

I HEREBY CERTIFY THAT I **HAVE** SERVED THE WITHIN SUMMONS:

SERVED

By delivering on the 23 Rd. day of April, 2010 at 12:57 P M. a copy of the summons and a copy of the Complaint to the following Defendant Baptist Memorial Hospital C/O Gregory Burke at 350 Humphreys Blvd., Memphis, Tn. 38120

Richard Brooks Jr.
Brooks Professional Process Server
6726 Shoreline Circle
Memphis, TN. 38141
PH: 901-370-6373 Cell: 901-497-6913

Signature of person accepting service

By: Richard Brooks
~~Sheriff~~ or other authorized person to serve process

JUNETTE L. BROOKS
STATE OF TENNESSEE
NOTARY PUBLIC
SHELBY COUNTY

April 24, 2010
Junette L. Brooks

MY COMMISSION EXPIRES:
March 16, 2011

RETURN OF NON-SERVICE OF SUMMONS

I HEREBY CERTIFY THAT I **HAVE NOT** SERVED THE WITHIN SUMMONS:

To the named Defendant _____

because _____ is (are) not to be found in this County after diligent search and inquiry for the following reason(s): _____

This _____ day of _____, 20_____.

By: _____
Sheriff or other authorized person to serve process

Docket No: CT-002067-10

IN THE (CIRCUIT/CHANCERY) COURT OF TENNESSEE FOR THE THIRTIETH JUDICIAL DISCTRICT AT MEMPHIS

SUMMONS IN A CIVIL ACTION

ANTHONY SNOW/JESSIE M. SNOW, Decd
Plaintiff

VS

TIMOTHY L. KEMP, M.D., et al.
Defendant

Bobby F. Martin, Jr., Esq.
Attorney for Plaintiff/Pro Se

(901) 217-7000
Telephone Number

(CIRCUIT/CHANCERY) COURT OF TENNESSEE
140 ADAMS AVENUE, MEMPHIS, TENNESSEE 38103
FOR THE THIRTIETH JUDICIAL DISTRICT AT MEMPHIS

SUMMONS IN CIVIL ACTION

Docket No. CT-002067-10

(•) Lawsuit
( ) Divorce

Ad Damnum $ _____

ANTHONY SNOW, Individually and as Next-of Kin of JESSIE M. SNOW, Deceased;	TIMOTHY L. KEMP, M.D., THMS WEST TENNESSEE MC, LLC and BAPTIST MEMORIAL HOSPITAL - COLLIERVILLE,
Plaintiff(s)	Defendant(s)

VS

TO: (Name and Address of Defendant (One defendant per summons))

Timothy L. Kemp, M.D.
c/o Baptist Collierville Hospital
1500 West Poplar
Collierville, TN 38017

Method of Service:

- ( ) Certified Mail
- ( ) Shelby County Sheriff
- ( ) Commissioner of Insurance ($)
- ( ) Secretary of State ($)
- ( ) Other TN County Sheriff ($)
- (✓) Private Process Server
- ( ) Other

($) Attach Required Fees

You are hereby summoned and required to defend a civil action by filing your answer with the Clerk of the Court and serving a copy of your answer to the Complaint on Bobby F. Martin, Jr., Esq., The Cochran Firm - Memphis Plaintiff's attorney, whose address is One Commerce Square, 26th Floor, Memphis, TN 38103 , telephone +1 (901) 217-7000 within THIRTY (30) DAYS after this summons has been served upon you, not including the day of service. If you fail to do so, a judgment by default may be taken against you for the relief demanded in the Complaint.

JIMMY MOORE Clerk

TESTED AND ISSUED April 27, 2010 By _____, D.C.

TO THE DEFENDANT:

NOTICE; Pursuant to Chapter 919 of the Public Acts of 1980, you are hereby given the following notice:
Tennessee law provides a four thousand dollar ($4,000) personal property exemption from execution or seizure to satisfy a judgment. If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a written list, under oath, of the items you wish to claim as exempt with the Clerk of the Court. The list may be filed at any time and may be changed by you thereafter as necessary; however, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment issued prior to the filing of the list. Certain items are automatically exempt by law and do not need to be listed. These include items of necessary wearing apparel (clothing) for yourself and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Bible and school books. Should any of these items be seized, you would have the right to recover them. If you do not understand your exemption right or how to exercise it, you may wish to seek the counsel of a lawyer.

FOR AMERICANS WITH DISABILITIES ACT (ADA) ASSISTANCE ONLY, CALL (901) 379-7895

I, JIMMY MOORE, Clerk of the Court, Shelby County, Tennessee, certify this to be a true and accurate copy as filed this

_____

JIMMY MOORE, Clerk

By: _____, D.C.

SERVED

RETURN OF SERVICE OF SUMMONS

I HEREBY CERTIFY THAT I **HAVE** SERVED THE WITHIN SUMMONS:

By delivering on the 26th day of April, 20____ at _____ M. a copy of the summons and a copy of the Complaint to the following Defendant Timothy L. Kemp C/O Baptist Hospital Collierville at 1500 W. Poplar Ave, Collierville, Tn. 38017 at 9:22 AM.

Richard Brooks Jr.
Brooks Professional Process Server
6725 Shoreline Circle
Memphis, TN. 38141
PH: 901-379-8373 Cell: 901-497-8913

Signature of person accepting service

By: _____
Sheriff or other authorized person to serve process

JUNETTE L. BROOKS
STATE OF TENNESSEE
NOTARY PUBLIC
SHELBY COUNTY

April 26, 2010

Junette L. Brooks

MY COMMISSION EXPIRES:
March 16, 2011

RETURN OF NON-SERVICE OF SUMMONS

I HEREBY CERTIFY THAT I **HAVE NOT** SERVED THE WITHIN SUMMONS:

To the named Defendant _____

because _____ is (are) not to be found in this County after diligent search and inquiry for the following reason(s): _____

This _____ day of _____, 20_____.

By: _____
Sheriff or other authorized person to serve process

Docket No: CT-002267-10

IN THE
(CIRCUIT/CHANCERY) COURT
OF TENNESSEE
FOR THE
THIRTIETH JUDICIAL
DISCTRICT AT MEMPHIS

SUMMONS IN A CIVIL ACTION

ANTHONY SNOW/JESSIE M. SNOW, Decd
Plaintiff

VS

TIMOTHY L. KEMP, M.D., et al.
Defendant

Bobby F. Martin, Jr., Esq.
Attorney for Plaintiff/Pro Se

(901) 217-7000
Telephone Number

IN THE CIRCUIT COURT OF TENNESSEE
FOR THE THIRTIETH JUDICIAL DISTRICT AT MEMPHIS, SHELBY COUNTY

FILED
APR 22 2010
CIRCUIT COURT CLERK
BY D.C.

ANTHONY SNOW, Individually and as Next of Kin of JESSIE M. SNOW, Deceased,

Plaintiff,

v.

TIMOTHY L. KEMP, M.D., THMS WEST TENNESSEE MC, LLC, and BAPTIST MEMORIAL HOSPITAL – COLLIERVILLE,

Defendants.

Div. VII

Docket No. CT-002067-10

Jury Demanded

CERTIFICATE OF GOOD FAITH

Medical Malpractice Case

PLAINTIFF'S FORM

A. In accordance with T.C.A. § 29-26-122, I hereby state the following: (Check item 1 or 2 below and sign your name beneath the item you have checked, verifying the information you have checked. Failure to check item 1 or 2 and/or not signing item 1 or 2 will make this case subject to dismissal with prejudice.)

☐ 1. The Plaintiff or Plaintiff's counsel has consulted with one (1) or more experts who have provided a signed written statement confirming that upon information and belief they:

(A) Are competent under § 29-26-115 to express opinion(s) in the case; and

(B) Believe, based on the information available from the medical records concerning the care and treatment of the Plaintiff for the incident(s) at issue, that there is a good faith basis to maintain the action consistent with the requirements of § 29-26-115.

Signature of Plaintiff if not represented, or Signature of Plaintiff's Counsel

or

X 2. The Plaintiff or Plaintiff's counsel has consulted with one (1) or more experts who have provided a signed written statement confirming that upon information and belief they:

(A) Are competent under § 29-26-115 to express opinion(s) in the case; and

(B) Believe, based on the information available from the medical records reviewed concerning the care and treatment of the Plaintiff for the incident(s) at issue and, as appropriate, information from the Plaintiff or others with knowledge of the incident(s) at issue, that there are facts material to the resolution of the case that cannot be reasonably ascertained from the medical records or information reasonably available to the Plaintiff or Plaintiff's counsel; and that despite the absence of this information there is a good faith basis for maintaining the action as to each Defendant consistent with the requirements of § 29-26-115. Refusal of the Defendant to release the medical records in a timely fashion, or where it is impossible for the Plaintiff to obtain the medical records shall waive the requirement that the expert review the medical records prior to expert certification.

Signature of Plaintiff if not represented, or Signature of Plaintiff's Counsel

B. You MUST complete the information below and sign:

I have been found in violation of T.C.A. § 29-26-122 0 prior times. (Insert number of prior violations by you).

Signature of Person Executing This Document

4/22/10
Date